DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 6320.5D
Code 0300
6 January 1997

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6320.5D

From: Commanding Officer

Subj: POLICIES AND PROCEDURES OF THE MEDICAL STAFF

Ref: (a) BUMEDINST 6010.17A
(b) Accreditation Manual for Hospitals, Joint Commission on the Accreditation for Healthcare Organizations
(c) BUMEDINST 6320.66A
(d) BUMEDINST 6320.67
(e) BUMEDINST 6010.13
(f) SECNAVINST 52ll.5D
(g) NAVHOSP29PALMSINST 6320.60D
(h) NAVHOSP29PALMSINST 6000.6D
(i) NAVHOSP29PALMSINST 6300.l
(j) NAVHOSP29PALMSINST 6320.92B
(k) NAVMED P-5066
(l) NAVHOSP29PALMSINST 6320.64B
(m) NAVHOSP29PALMSINST 1752.1A
(n) NAVHOSP29PALMSINST 6220.2B
(o) NAVHOSP29PALMSINST 60l0.8B
(p) NAVHOSP29PALMSINST 5530.3A
(q) NAVHOSP29PALMSINST 6460.2D
(r) NAVHOSP29PALMSINST 5420.5C
(s) NAVHOSP29PALMSINST 3440.1A
(t) NAVHOSP29PALMSINST 1500.8C
(u) BUMEDINST 1500.15A
(v) NAVHOSP29PALMSINST 6301.1
(w) NAVHOSP29PALMSINST 6320.62C
(x) NAVHOSP29PALMSINST 6530.2A

Encl: (l) Policies and Procedures of the Medical Staff

l. Purpose. To establish the policies and procedures that govern the physician staff and non physician health care providers at the Naval Hospital, Twentynine Palms, California, hereinafter simply referred to as "medical staff." These policies and procedures create a framework within which medical staff members can act with a reasonable degree of freedom and confidence. This instruction has been completely revised and must be read in its entirety.

2. Cancellation. NAVHOSP29PALMSINST 6320.5C.

3. Applicability. Applies to all military (Active Duty and Reserve) and civilian health care practitioners who are assigned to, employed by, contracted to, or under partnership agreement with Naval Hospital, Twentynine Palms.

a. Per reference (a), all health care practitioners who are responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical care must be subject to credentials review and must be granted a medical staff appointment with delineated clinical privileges by the privileging authority (Commanding Officer) before independently providing patient care. These practitioners are members of the medical staff.

b. Clinical support staff, while required to be educationally qualified and currently competent to provide health care services, are not authorized to provide care independently, are not eligible to participate in the privileging process, and are therefore not eligible to be members of the medical staff.

3. Background. References (a) through (x) set forth the requirements of the United States Navy, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and local MTF policies which govern the medical staff at Naval Hospital, Twentynine Palms, California.

4. Policy. The contents of this instruction, the cited references and enclosure (l) constitute the expected military, personal and professional standards of performance by members of the medical staff. Deviations from these standards may result in loss or limitation of privileges as deemed appropriate by the Commanding Officer upon the recommendation of the Executive Committee of the Medical Staff (ECOMS), Naval Hospital, Twentynine Palms.

a. The medical staff policies of this instruction (enclosure (l), Section I) define the mechanism of governance of the medical staff within the standards of references (a) and (b). The medical staff has responsibility for the quality of the medical services provided as well as accountability to the Commanding Officer. The medical staff organization and functions described herein seek to assure the provision of the highest achievable quality of patient care.

b. The medical staff procedures section of this instruction (enclosure (l), Section II) specifically relate to the responsibilities of the medical staff in the care of patients. These policies and procedures are consistent with command policies and approved by the Commanding Officer.

5. Action

a. Directors shall ensure all Naval Hospital, Twentynine Palms' instructions are readily available to all of their directorate medical staff members and that the policies and procedures contained therein are enforced.

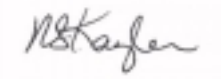
b. Each medical staff member shall:

(l) Be required to apply for and be granted medical staff appointments and specific clinical privileges before they can participate in patient care at this Medical Treatment Facility.

(2) Verify acknowledgement of receipt of Policies and Procedures of the Medical Staff contained within the Clinical Privileges Application. This acknowledges that the individual pledges to abide by the policies and procedures and to provide patient care ethically and consistent with accepted standards of care.

c. Head, Performance Improvement Department shall ensure a copy of this instruction is provided to all medical staff members upon reporting aboard, and whenever it is revised.

6. Review. Any proposed change, amendment or revision to this instruction shall be brought before the ECOMS for review. Additionally, the members of the Medical Staff and ECOMS shall review this instruction at least annually and shall forward any revisions to the Commanding Officer for approval. This process shall insure currency with Navy directives and amendments to the accreditation standards.



R. S. KAYLER

Distribution:
List A and D

DEPARTMENT OF THE NAVY
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MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:

NAVHOSP29PALMSINST 6320.5D CH-1
Code 0300
3 October 1997

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6320.5D CHANGE TRANSMITTAL 1

From: Commanding Officer

Subj: **POLICIES AND PROCEDURES OF THE MEDICAL STAFF**

1. **Purpose**. To transmit direct pen changes to the basic instruction.

2. **Action**. In the basic instruction, page 1-10, after bullet "q", add paragraph 2 to read "In certain cases, it may be most beneficial to have department head responsibilities divided between two people in medical staff clinical departments. All activities outlined in bullets a-q will be performed. A non-physician clinic manager may be appointed and be responsible for all administrative activities of the department. A credentialed physician will be appointed as Senior Medical Officer responsible for all clinical activities of the department".

J. A. NORTON
By direction

DISTRIBUTION:
List A

POLICIES AND PROCEDURES FOR THE MEDICAL STAFF

POLICIES FOR THE MEDICAL STAFF

1. General

a. These policies and procedures become effective on 31 December 1996.

b. Each current member of the medical staff and each applicant for membership must be oriented to the Naval Medical Staff Bylaws and these Policies and Procedures. They must agree in writing that their activities as members of the medical staff are bound by them.

c. Each current member of the medical staff and each applicant for membership must be provided a copy of, or have ready access to a copy of, the Naval Medical Staff Bylaws and these Policies and Procedures.

d. When significant changes are made in these policies and procedures, all practitioners must be notified in writing and provided a copy of, or ready access to, the revised text.

e. In any deliberation affecting the discharge of medical staff responsibilities, there must be medical staff representation and participation.

f. The medical staff must have in place mechanisms designed to:

(l) Involve the members of the medical staff in activities to measure, assess, and improve organizational performance.

(2) Communicate to appropriate members of the medical staff the findings, conclusions, recommendations, and actions taken to improve organizational performance.

(3) When the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review and the periodic evaluations of a licensed independent practitioner's competence, per the "Medical Staff" chapter of reference (c).

2. Organization

a. The Executive Committee of the Medical Staff (ECOMS):

(1) ECOMS is the medical staff representative and participates in each MTF deliberation affecting the discharge of professional responsibilities.

(2) Membership Eligibility. ECOMS consists of five voting members appointed by the Commanding Officer. All members of the medical staff are eligible for appointment to the executive committee, but a majority of executive committee members must be fully licensed physician members of the medical staff actively practicing in the facility.

(3) Membership Structure and Selection. Voting Membership will consist of the DAS, DMS, and DSS as well as two at large members elected by the medical staff. Privileged non-physician healthcare providers are eligible for election to an at-large position on ECOMS. If a non-physician provider is not elected, the non-physician providers may select one of their number to represent them as a non-voting/ad hoc member of ECOMS, serving in this capacity for one year.

(4) Period of Membership. Initial appointment and renewal of appointment to the executive committee shall not exceed a 2 year period. Elections for at-large members will be conducted annually.

(5) Termination of Membership. Executive committee membership automatically terminates upon revocation, suspension, or limitation of clinical privileges for reasons related to conduct or professional performance listed in reference (d) or for other reasons at the discretion of the privileging authority.

(6) Membership and Voting Status. Membership shall include the Executive Officer and the Performance Improvement Physician Advisor (PIPA). The Chief of the Medical Staff, as appointed by the Commanding Officer, will serve as Chairman of ECOMS. Non-medical staff members of the executive committee include the Director for Nursing Services, the Regimental Surgeon and the Command Performance Improvement Coordinator. Non-medical staff members shall be non-voting members. The membership status of a non-medical staff Executive Officer shall be ex officio. The Executive Officer is a non-voting member, regardless of corps.

(7) Meeting Frequency, Minutes and Attendance. The executive committee will meet at least eleven times per year at

approximately monthly intervals and will document its conclusions, recommendations, and actions taken in minutes submitted to the Commanding Officer for approval via the Executive Officer and Performance Improvement Coordinator. A member of the executive committee must attend at least 50 percent of all scheduled meetings in each calendar year to remain eligible for continued membership on the committee. Attendance will be monitored at each meeting, annotated “P” for present and “A” for absent. Attendance will be reviewed annually.

(8) Responsibilities of the Executive Committee. The Executive Committee is responsible for making recommendations directly to the Commanding Officer for approval on at least the following matters:

(a) Structure of the professional staff.

(b) Reviewing, granting, limiting, revoking, suspending, denying, or terminating a practitioner's appointment to the professional staff and delineated clinical privileges and the policies and procedures.

(c) Organization of medical staff performance assessment and improvement activities, including the mechanism used to conduct, evaluate, and revise such activities.

(d) Mechanisms for peer review panel hearing procedures and the mechanism by which medical staff membership may be terminated, consistent with reference (d).

(9) The Executive Committee will review and act on reports and recommendations from medical staff committees, clinical directorates or departments, process action teams and other assigned activity groups. Significan directorate activities will be reported each month to the Executive Committee in the following manner: The Director of Surgical Services (DSS) will review and report on the previous month’s Surgical Directorate meeting minutes. The Director of Medical Services (DMS) will review and report on the previous month’s Medical Directorate meeting minutes. The Director of Ancillary Services (DAS) will review and report on the previous month’s Ancillary Services Directorate meeting minutes. The Performance Improvement Physician Advisor (PIPA) will review and report on the previous month’s Morbidity and Mortality (M&M) meeting minutes.

(l0) The Executive Committee will review an annual evaluation of the effectiveness of the medical staff's participation in the facility's performance assessment and appraisal of the facility's Performance Assessment and Improvement Program, as required by reference (e).

(ll) The Executive Committee adopts and amends local policies and procedures of the medical staff subject to the approval of the local representative of the privileging authority. Such policies and procedures must be developed with due regard for assuring the same level of quality of patient care by all individuals with delineated clinical privileges, within medical staff departments, and across directorates and departments.

(12) The Executive Committee is responsible for disseminating information from medical staff meetings to facility medical staff, clinical support staff, administration, and the privileging authority, following reference (a). The medical staff may communicate with all levels of governance involved in policy decisions affecting patient care services.

(13) Keeps the medical staff informed of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation program and the accreditation status of the hospital, and ensures that medical staff members are actively involved in the accreditation process.

b. Directorates

(l) The medical staff at the Naval Hospital, Twentynine Palms is departmentalized into professional services, hereinafter referred to as departments. Each department with medical staff members falls within one of the three directorates, the Medical Directorate, Surgical Directorate or the Ancillary Services Directorate.

(2) The directors are appointed by the Commanding Officer with the following responsibilities:

(a) Are accountable to the Commanding Officer for all patient care activities as well as professional and administrative activities within their directorate.

(b) Are responsible for continued surveillance of the professional performance of all individuals who have clinical privileges in their directorate.

(c) Shall recommend or endorse to the ECOMS departmental specialty specific criteria for the granting of:

1 Medical Staff Appointments

a Initial staff appointment with clinical privileges

b Active staff appointment and reappointment with clinical privileges

c Affiliate staff appointment and reappointment with clinical privileges

2 Shall recommend to the ECOMS clinical privileges for each member of their directorate; assure that until they are granted at least initial appointments, medical staff members assigned to their directorate render no care except in the case of emergencies; and assure that all applications meet the documentation and verification requirements. Privilege categories:

a Regular

b Temporary

c Supervised

3 Shall ensure that the quality and appropriateness of patient care provided within their directorate are monitored and evaluated. Documentation of results of reviews shall include an objective assessment and conclusions. System problems identified and all provider-related deviations from the standards of care shall be reported in accordance with command directives.

4 Shall ensure that all directorate members attend meetings of committees to which they are assigned.

5 Shall provide guidance on the overall medical policies of the command and specific recommendations

concerning their directorate's services, Performance Improvement and credentialing activities.

6 Shall ensure that all medical records are completed promptly and are acceptable in content and quality in accordance with governing directives.

7 Shall ensure that all directorate members participate in continuing education activities to maintain professional skills at an optimal level and meet credentialing and readiness requirements.

8 Shall ensure timely preparation of all reports pertaining to their directorate.

9 Shall be responsible for enforcement of all command and higher authority directives pertaining to their directorate. Establish and maintain additional written policies and procedures applicable to their directorate as required.

10 Shall ensure that physician supervisors are appointed in writing for all Nurse Practitioners, Nurse Midwives, Nurse Anesthetists, and Physician Assistants assigned to their directorate.

11 The directors meet with the Commanding Officer at least weekly. In addition, the directors meet monthly with their respective department heads. If the department head is unable to attend this meeting, then a substitute must be sent. The minutes of the various directorate meetings are submitted to the Commanding Officer via the Performance Improvement Committee and ECOMS.

12 The Director, Ancillary Services: The Director Ancillary Services is responsible to the Commanding Officer for the coordination and efficient operation of all ancillary services and shall establish and maintain an effective Performance Improvement Program within the directorate in accordance with these procedures and command directives.

a The Director, Ancillary Services is a member of the medical staff.

b The Director, Ancillary Services shall keep the Commanding Officer advised concerning the provisions

of ancillary services, efficient and effective utilization of ancillary personnel and material resources, their training requirements and implementation of policies, criteria and standards as they pertain to the provisions of ancillary services.

c The departments within the Directorate of Ancillary Services include Optometry, Laboratory, Physical Therapy, Pharmacy, Radiology, and Occupational Health/Preventive Medicine.

13 The Director, Medical Services: The Director, Medical Services is responsible to the Commanding Officer for the coordination and efficient operation of all medical matters and shall establish and maintain an effective Performance Improvement Program within the directorate in accordance with these procedures and command directives.

a The Director, Medical Services shall keep the Commanding Officer advised concerning the provisions of medical services, efficient and effective utilization of medical personnel and material resources, their training requirements and implementation of policies, criteria and standards as they pertain to the provisions of medical services.

b The Director, Medical Services is a physician board certified or board eligible in a medical specialty and a member of the medical staff.

c The departments within the medical directorate include Emergency Medicine, Family Practice, Internal Medicine, Mental Health, Pediatrics, and Military Sick Call.

14 The Director, Surgical Services is responsible to the Commanding Officer for the coordination and efficient operation of all surgical matters and shall establish and maintain an effective Performance Improvement Program within the directorate in accordance with these procedures and command directives.

a The Director, Surgical Services shall keep the Commanding Officer advised concerning the provisions of surgical services, efficient and effective utilization of surgical personnel and material resources, their training

requirements and implementation of policies, criteria and standards as they pertain to the provisions of surgical services.

b The Director, Surgical Services is a physician board certified or board eligible in a surgical specialty and is a member of a medical staff.

c The departments within the surgical directorate include Anesthesia, General Surgery, Obstetrics and Gynecology, and Orthopedics.

15 Chief of the Medical Staff: This position, appointed by the Commanding Officer, is held by a senior physician from the Medical, Surgical, or Ancillary Services directorate. The Chief of the Medical Staff serves concurrently as Chairman of ECOMS.

16 Department Heads must be either board certified, board eligible, or affirmatively establish through the privilege delineation process that they possess comparable competence.

1 Department Heads are appointed by the Commanding Officer with the advice of the appropriate director and have the following responsibilities:

a Are accountable to the Commanding Officer through their director for all clinically and administratively related activities within the department.

b Are responsible for continued surveillance of the professional performance of all individuals who have clinical privileges in their departments.

c Shall recommend to the directors departmental specialty specific criteria for the granting of:

l) Initial staff appointment with clinical privileges

2) Active staff appointment and reappointment with clinical privileges

3) Affiliate staff appointment and reappointment with clinical privileges

d Shall:

1) Recommend clinical privileges for each member of their department based on the applicant's professional qualifications (health status, current competence, verified licensure, and education and training);

2) Use practitioner specific results of performance improvement and risk management monitoring activities when making recommendations for professional staff appointments and reappointments with clinical privileges;

3) Assure that until they are granted at least initial appointment, medical staff members assigned to their department render no care except in the case of emergencies.

e Shall ensure that the quality and appropriateness of patient care provided within their department is monitored and evaluated. Documentation of results of reviews shall include an objective assessment and conclusions.

f Shall communicate to appropriate members of the medical staff the findings, conclusions, recommendations, and actions taken to improve organizational performance.

g Shall ensure that all department members attend meetings of committees to which they are assigned.

h Shall provide guidance on the overall medical policies of the command and specific recommendations concerning their department's services, Performance Improvement and credentialing activities.

i Shall ensure that all medical records are completed promptly and are acceptable in content and quality in accordance with governing directives. References (i) and (l).

j Shall ensure that all department members participate in orientation and continuing education activities to maintain professional skills on an optimal level and meet credentialing and readiness requirements. References (t) and (u).

k Shall be responsible for enforcement of all command and higher authority directives pertaining to their department.

l Shall ensure that physician supervisors are appointed in writing for all Independent Duty Corpsmen, Nurse Practitioners, Nurse Midwives, Nurse Anesthetists and Physician Assistants assigned to their department.

m Shall ensure the integration of the department into the primary functions of the organization.

n Shall ensure the coordination and integration of interdepartmental and intradepartmental services.

o Shall develop and implement policies and procedures that guide and support the provisions of services within the department.

p Shall recommend a sufficient number of qualified and competent persons to provide care and service.

q Shall make recommendations to the directors for space and other resources needed to provide patient care services, on or off site.

3. Improving Organizational Performance. As part of the facility's performance improvement program, the medical staff must participate in performance assessment and improvement activities which are carried out collaboratively throughout the organization, across multiple structural and staffing components, involving the appropriate departments and disciplines, as needed. The primary focus in improving performance shall be on the organization's systems and processes rather than on the performance of individuals. While most problems and opportunities for improvement derive from process weaknesses, not individual competence and performance, it is imperative that directors, department heads, and the entire medical staff are actively involved in establishing and maintaining a qualified and competent medical staff. The important patient care functions shall include the following:

a. Operative and Other Invasive Procedures

(l) Multidisciplinary Collaboration. Measurement,

assessment, and improvement of operative and other invasive procedures must be performed in a collaborative and multidisciplinary fashion, including all individuals and professions involved in providing these services. The medical staff must play a central role in this process and is responsible when the review focuses on the performance of privileged providers.

(2) Priorities for Measurement. The medical staff must participate in the prioritization of its operative and other invasive procedures, selecting high priority procedures or categories of procedures for measurement. The variety of procedures measured must be representative of the organization's scope of care and priorities. For each category chosen, the sample of cases selected for measurement must be statistically representative.

(3) Focus on Processes. Measurement must include the processes related to: (l) selecting appropriate procedures, (2) preparing patients for procedures, (3) performing procedures and monitoring patients, and (4) providing post-procedure care. It is not necessary to measure all four processes for each procedure selected; however, all four of these processes must be included in the overall measurement of operative and other invasive procedures. Time-limited, focused studies are not the goal of this activity; rather, the goal is measurement of a performance dimension over a period of time to understand process variation.

(4) Diagnostic Discrepancies (Sentinel Event Performance Measure): An intensive assessment must be initiated in response to all major discrepancies or patterns of discrepancies, between pre-operative and post-operative (or pathologic) diagnoses.

(5) Frequency of Measurement, Assessment, and Reporting. Measurement must be an ongoing process; assessment and reporting frequency must be at least quarterly.

b. Use of Medications

(1) Multidisciplinary Collaboration: Measurement, assessment, and improvement of medication use must be performed in a collaborative and Multidisciplinary fashion, including pharmacy staff, nursing staff, management and administrative staff, medical staff, and others, as needed. The medical staff must play a central role in this process and is responsible when

the review focuses on the performance of a licensed independent practitioner with clinical privileges.

(2) Priorities for Measurement: The Pharmacy and Therapeutics Committee (Ref w.) will establish priorities for measurement of its use medications, selecting high priority medications or categories of medications for measurement. The variety of medications measured must be representative of the organizations scope of care and priorities. For each medication or category of medication chosen, the sample of cases selected for measurement must be statistically representative.

(3) Focus on Processes: Measurement must include the processes related to; (l) prescribing and ordering, (2) preparing and dispensing, (3) administering, and (4) monitoring the effects of medications on patients. It is no necessary to measure all four processes for each medication selected; however, all four of the processes must be included in the organizational's overall measurement of medication use. Time-limited, focused studies are not the goal of this activity; rather, the goal is measurement of performance dimension over a period of time to understand process variation.

(4) Adverse Drug Reactions (Sentinel Event Performance Measure): The Pharmacy and Therapeutics Instruction (ref w) includes the definition of a significant adverse drug reaction (ADR) as well as the procedure to obtain data regarding the occurrence of ADRs.

(5) Frequency of Measurement, Assessment, and Reporting: Although measurement must be an ongoing process, assessment and reporting frequency must be at least quarterly.

(6) Maintenance of the Drug Formulary: The Pharmacy and Therapeutics Committee Instruction (ref)contains the policies and procedures that address the maintenance of the drug formulary.

c. Use of Blood and Blood Components

(l) Multidisciplinary Collaboration: Measurement, assessment, and improvement of the use of blood and blood components must be performed in a collaborative and multidisci-plinary fashion, including all individuals and professions involved in providing this service. The medical staff must play

a central role in this process and is responsible when the review focuses on the performance of a licensed independent practitioner with clinical privileges.

(2) Priorities for Measurement: The Blood Usage Committee (ref x.) will establish priorities for measurement of its use of blood and blood components, selecting high priority components for measurement. The variety of blood components measured must be representative of the organization's scope of care and priorities. For each component, the sample of cases selected for measurement must be statistically representative.

(3) Focus on Processes: Measurement must include the processes related to; (l) ordering, (2) distributing, handling, dispensing, (3) administering, and (4) monitoring the effects of blood and blood components on patients. It is not necessary to measure all four processes for each component selected; however, all four of the processes must be included in the organization's overall measurement of blood and blood component use. Time-limited, focused studies are not the goal of this activity; rather, the goal is measurement of a performance dimension over a period of time to understand process variation.

(4) Transfusion Reactions (Sentinel Event Performance Measure): The Blood Usage Committee has developed policies and procedures (ref) which define the criteria used to identify transfusion reactions. All confirmed transfusion reactions must receive intensive assessment.

(5) Frequency of Measurement, Assessment, and Reporting. Although measurement must be an ongoing process, assessment and reporting frequency must be at least quarterly.

d. Medical record review

(l) Multidisciplinary Collaboration: Medical record review is performed in a collaborative, multi-departmental fashion by the Medical Records Review Committee (ref l.) The medical staff must play a central role in this process and is responsible when the review focuses on the performance of a licensed independent practitioner with clinical privileges.

(2) Focus of Measurement. Each medical record, or a representative sample of medical records, must contain the items listed in references (a) and (b). Inpatient medical records must be completed within 30 days.

(3) Frequency of Measurement, Assessment, and Reporting. The completeness, accuracy, and timely completion of information in medical records must be reviewed and documented at least quarterly.

e. Morbidity and Mortality Committee. The purpose of the Morbidity and Mortality meeting is:

(1) For furtherance of continuing medical education.

(2) To discuss standard of care issues which are deemed serious enough to merit discussion beyond the directorate level, particularly those cases involving significant Unexpected Event Reports, JAG investigations, etc. Less significant UER's which do not cross department/directorate lines) may be discussed and closed at the department or directorate level. At the M&M Meeting, the Medical Staff shall render an opinion as to whether the standard of care was met or breached. The Performance Improvement Physician Advisor will report the M&M discussion at the following ECOMS meeting, and ECOMS will review any case considered to be outside the standard of care. A copy of any validated UER will be placed in the provider's CAF (Clinical Activity File) and ICF (Individual Credentials File). ECOMS may make recommendations to the Commanding Officer regarding further training, limitations of privileges, etc, as may be warranted.

(3) To discuss the results of autopsies.

(4) To discuss drug utilization and blood utilization reviews; and pertinent medical staff issues from the following committees or functions: Bioethics Committee, Pharmacy and Therapeutics Committee, CPR Committee, Infection Control, Risk Management, Utilization Management.

(5) Meetings are held as needed but not less than quarterly. Attendance at Morbidity and Mortality meetings is strongly encouraged for all privileged medical staff members and will, at minimum, consist of a representative from the appropriate specialty for each case discussed. Individual providers involved in the cases to be discussed will be notified in advance so they may attend and participate in the discussion. M&M meetings are chaired by the Performance Improvement Physician Advisor, who is responsible for determining the agenda based on input from the directors, department heads, other medical staff

members, and the Performance Improvement Coordinator. Minutes of the meeting are fowarded to ECOMS for discussion and are maintained in the Performance Improvement Office.

f. When an individual has performance problems that he/she is unable or unwilling to improve, ECOMS will make appropriate recommendations to the privileging authority (Commanding Officer) regarding modifications in clinical privileges or job assignments.

4. Appointments and Reappointments. Medical staff appointments with clinical privilege requirements are contained in references (a) and (c) and include the following:

a. In accordance with DoD Guidelines, appointment types include the following:

(1) Initial: Formerly called “Provisional,” Initial appointment is the first Dod MTF appointment and leads to Active/Affiliate staff appointment. It is a proctored period not to exceed 12 months. It is NOT a period of supervision. Initial appointment will occur only once in a Navy career.

(2) Active Staff Appointment: The provider meets all qualifications for medical staff membership and is expected to fully participate in medical staff activities. The provider abides by all medical staff bylaws, Policies and Procedures, and Rules and Regulations, and is responsible for all information in medical staff bylaws. This period is not to exceed 24 months.

(3) Affiliate Appointment: This category includes contracted providers, consultants, and resource sharing providers who have successfully completed their Initial Appointment. These providers are not expected to be full participants in medical staff activities, although they must be kept informed of medical staff bylaw changhes. The Affiliate Appointment period is not to exceed 24 months.

(4) Temporary Appointment: Rarely used, this appointment type is used when time constraints will not allow a full credentials review and there is a pressing patient need. It is required when providers practicing under temporary privileges will admit.

(5) "None" Appointment: Unlicensed providers are not

appointed to the Medical Staff. Categories include: Interns, Residents, Clinical Psychologists in training.

b. In accordance with DoD Guidelines, Privilege Categories include the following:

(1) Regular: These providers have documented licensure, education and training, competency, and health status to engage in independent practice.

(2) Temporary: This is a time-limited privilege category wherein time constraints will not allow a full credentials review. Licensure and current competence may be verified by phone. These privileges may be granted with or without a temporary medical staff appointment.

(3) Supervised: Identifies non-licensed or non-certified providers who, per JCAHO, cannot be appointed to the Medical Staff or practice independently.

c. Medical Staff Appointments and Clinical Privileges: Privileges will be granted only to medical staff applicants who have provided evidence that their professional license status, training, experience, current competence, ability, judgment, professional ethics and health status reflect their ability to exercise that degree of care, judgment and skill which other providers of good standing would exercise in the same or similar circumstances. Requirements include the following:

(l) All medical staff eligible personnel assigned or employed at Naval Hospital Twentynine Palms must apply for and be accepted as a member of the medical staff either on an initial or active/affiliate staff appointment basis before they may independently practice their professional skills within the facility. This includes the following:

(a) Providers permanently assigned to Naval Hospital Twentynine Palms.

(b) Providers assigned on a permanent basis to operating forces located at Twentynine Palms.

(c) Temporary Additional Duty providers.

(d) Guest physicians/providers who do not have priviliges at this facility are NOT permitted to treat patients at this facility. Guest physicians/providers may be granted privileges at the discretion of the Commanding Officer, based on recommendations from the Department Head and Director, if all appropriate privileging elements have been verified by the Credentials/Performance Improvement Office. Medical students and residents in training are not granted clinical privileges, and when here as guests, are NOT permitted to treat patients. Medical students and residents who are rotating through this hospital as part of their training will not be privileged, but may attend to patients under the direction and guidance of a privileged staff member, with specific responsibilities and restrictions outlined in a Letter of Supervision. Administrative management of medical students will be provided by the Medical Student Coordinator, with oversight and assistance from the Performance Improvement Office. Medical Students and residents accompanying consulting specialty physicians from another military treatment facility (for example, NMC San Diego and NH Camp Pendleton) function under the direct supervision of that privileged physician, and do not require a Letter of Supervision.

(e) Applications for appointment and renewal to the medical staff shall coincide with the request for specific clinical privileges. Care shall be exercised to ensure that clinical privileges sought and granted are appropriate to the provider's training, specialty, abilities and experience; are specific to the facility's healthcare delivery needs; and are within the capabilities of the facility's support services. Applicants shall:

1 Complete the Personal and Professional Information Sheet to the best of their ability and provide the necessary records and documentation of professional qualifications if not previously made available at the time of application.

2 Consent to the inspection of records and documents pertinent to their licensure, specific training and experience, current competence and health status. If requested, the applicant will be expected to appear for interviews.

3 Agree, in writing, to abide by the Policies and Procedures of the Medical Staff. Each provider shall be provided copies of the BUMED Bylaws and this instruction, and acknowledge receipt of these copies.

(2) Core privileges are automatically included in the privileging request. Core privileges are defined as those privileges which, as a group, constitute the expected baseline scope of care for a fully-trained and currently competent practitioner of a specific health care specialty. Core privileges must be applied for and granted as a single entity. Because core privileges constitute a representative baseline scope of care, not all privileges in the core are required or expected to be exercised at all times in every facility. Those privileges not supported by this facility will be marked with an asterisk (*) on the privilege sheet. The privileging authority will inform practitioners in a timely manner of any facility-specific policies or procedure restrictions which would preclude the provision of health care services defined by core privileges. The core privilege sheets are not to be modified locally. Changes to the core privilege sheets can be made only by the Chief, BUMED, following review by the appropriate specialty advisor and chief of the appropriate corps.

(3) Supplemental privileges must be specifically requested by each applicant in accordance with the applicant's competence and facility support. Supplemental privileges are itemized, facility-specific privileges that are relevant to the specific health care specialty, but lie outside the core scope of care due to the level of risk, the requirement for unique facility support staff or equipment, or are too technically sophisticated or new to yet be included in the core scope of care. Supplemental privileges can be requested and granted on an item-by-item basis using predetermined department, specialty-specific criteria. These criteria must be developed by the department, endorsed by the ECOMS, and approved by the privileging authority. The supplemental privilege lists may be modified locally to reflect the scope of care that the facility can support and expects to provide.

(4) Active (or Affiliate) staff appointments shall be requested by any applicant who has held a staff appointment with clinical privileges within the previous two years at another Naval Medical Treatment Facility. The evaluation of clinical competence in this matter shall be accomplished by review of the current Performance Appraisal Report, NAVMED 6320/29 (Rev. 4-91), from the departing facility. Immediate Active (or Affiliate) Staff Appointment may be granted if recommended by the department head, director, ECOMS, and approved by the Commanding Officer (Privileging Authority). When an Active (or Affiliate) Staff

Appointment is not granted, Initial Appointment must be requested.

(5) Initial Staff Appointments are granted by the Privileging Authority after verification of professional qualifications and before providers are allowed to practice. Initial Appointments are the first DoD MTF appointment. Initial appointments are granted to those practitioners who have completed Graduate Medical Education at non-Navy facilities, or have been working in a non-Navy facility, and shall be assigned for a period not to exceed one year. The period serves as a time for the department head, director and ECOMS to evaluate the provider's demonstrated competence to perform core and supplemental clinical privileges and compliance with the Policies and Procedures of the Medical Staff. Initial Appointment is a time of proctoring, not a period of supervision. The initial appointment shall not be allowed to expire before the granting of Active Staff Appointment.

(6) The department head or director, as appropriate, shall submit a Performance Appraisal Report, NAVMED 6320/29 (Rev. 4/91), to support the recommendation for the renewal of privileges. PARs relating to the clinical dietician will be completed and submitted by the Director, Medical Services. The ECOMS shall submit its recommendation for Active (or Affiliate) appointment to the Commanding Officer. The provider shall receive written confirmation to the original request for Active (or Affiliate) appointment. The ECOMS shall ensure that the process leading to granting of active/affiliate appointments has included input from Performance Improvement activities.

(7) Active/Affiliate Appointments, once granted, must be adhered to by the medical staff member. The medical staff member's performance shall be monitored through Performance Improvement and peer review activities. Active/Affiliate staff appointments will be in effect for a period not to exceed 2 years.

(8) Within 60 days prior to the expiration of an Active or Affiliate staff appointment, a renewal must be requested, if eligibility to practice is to be uninterrupted. Renewal or revision of clinical privileges is based on an appraisal of the individual at the time of renewal. The appraisal includes information concerning the individual's current licensure, health status, professional performance, clinical/technical skills,

results of Performance Improvement and peer review activities, attendance at required meetings and other reasonable indicators of continuing qualification. Renewal will include review and evaluation by the department head, director, and ECOMS. ECOMS shall ensure that Performance Improvement activity results and peer recommendations are used in the renewal process. The Performance Appraisal Report, NAVMED 6320/2 (Rev. 4/91), shall be completed for each renewal of privileges. ECOMS shall submit its recommendation to the Commanding Officer. The provider shall be informed in writing that renewal for Active/Affiliate appointment has been continued or modified.

(9) In accordance with ref (c), no local privileging authority credentialing is required for Combined Arms Exercise (CAX) providers to utilize laboratory, pharmacy, or radiology services. CAX providers must have an Appendix “N” and Appendix “Q” on file if they wish to engage in direct patient care within this facility. CAX physicians are not ordinarily granted admission privileges. If the provider has been on station for a period of two weeks or longer and rendered direct patient care services, either inpatient or outpatient, at this facility, a PAR must be completed by the cognizant director and forwarded via ECOMS to the privileging authority.

(10) In accordance with ref (c), providers permanently assigned to operating forces on board MCAGCC do not require local privileging authority credentialing to utilize Laboratory, Pharmacy, or Radiology services. Providers must have an Appendix "N" and an Appendix “Q” on file if they wish to engage in direct patient care, inpatient or outpatient, within this facility. Admission privileges will be granted commensurate with the provider's training, specialty, abilities and experience. Admission privileges shall be specific to the facility's healthcare delivery needs and shall be within the capabilities of the facility's support services. If the provider engages in direct inpatient or outpatient services within this facility during his or her tenure, a PAR must be completed by the cognizant Director and forwarded to the First Marine Division Surgeon via ECOMS prior to renewal of privileges or when the member transfers.

(l1) Emergency Privileges. Providers, to the degree permitted by their license, certifying board, or Navy Regulations are expected to take all possible measures to save the life or limb of a patient in the case of an emergency. Accordingly,

emergency privileges are automatically awarded. The provisions of this paragraph do not replace the requirement for providers assigned to the Emergency Department to hold appropriate staff appointments.

(l2) License Requirements. Per reference (a), all Department of Defense (DOD) physicians, contract and partnership physicians, advanced practice nurses (nurse anesthetists, nurse midwives, nurse practitioners), psychologists, optometrists, physical therapists, and dieticians must possess a valid current license. Failure to maintain a current license may result in administrative suspension of privileges or other action depending upon the circumstances and as determined by ECOMS.

b. Adverse Credentials Actions, Fair Hearing Plan and Appeal Process are contained in reference (d). Immediate abeyance of privileges will occur by authority of the Commanding Officer whenever reasonable concern exists that provider conduct or impairment presents a real or potential threat to patient safety.

c. Individual Credentials Files (ICF) are maintained on each medical staff member in accordance with reference (c). Each provider is expected to ensure that his/her professional qualifications and application information are current and correct at all times.

d. Clinical Activity Files (CAF) are used to provide information in completing performance appraisals and are maintained on each medical staff member in accordance with reference (c).

(l) CAFs are maintained in the following manner:

(a) Individual provider CAFs will be maintained by the respective department head. In a single or two provider department, the CAFs may be maintained by the director, at their discretion. Exception: Clinical Dietician CAFs will be maintained by the Director of Medical Services.

(b) Department head CAFs will be maintained by the respective director.

(c) Clinical Directors' CAFs will be maintained by the department head of that particular specialty. In the case of

a clinical director and department head being the same person, the CAF will be held by the Chief of the Medical Staff/Chairman of ECOMS.

(d) CAFs shall maintain the following items:

1 Results of chart review and peer review activities.

2 Practice volume data: number of admissions, number of outpatient encounters, number of major or selected procedures.

3 Medical Staff performance improvement measures: Provider-specific results of monitoring a) Surgical and Invasive procedures, b) Use of Blood and Blood Products, c) Use of Medications, d) Medical Record Pertinence review

4 Facility-wide monitors: Provider-specific results of monitoring a) Utilization Review, b) Infection Control, c) Patient Contact/Satisfaction Program, d) Risk Management Activities (provider-specific JAGMAN investigations, litigation reports, Focused QA reviews, validated UERs, etc)

5 Professional development: Documentation of CME activities, including ACLS, ATLS, PALS, etc.

6 Miscellaneous items such as letters of appreciation.

5. Continuing Education Requirements

a. Each medical staff member shall participate in continuing education activities that relate to appointments granted.

(l) Command-sponsored educational activities shall relate, at least in part, to the type and nature of care offered by the command; the findings of Performance Improvement activities; and the expressed educational needs of individuals with clinical appointments.

(a) Each individual's participation in continuing education is documented and considered at the time of reappointment to the medical staff and/or renewal or revision of an individual's clinical staff appointment.

(b) In accordance with references (t),(u), and (v),

resuscitative medicine training requirements vary according to specialty, type of clinical activities engaged, and operational or overseas contingencies. Department-specific resuscitative medicine certification requirements are explicitly stated in each department's privileging/credentialing criteria. The following is a brief summary:

1 Basic Life Support (BLS) certification is required for ALL Navy Medical Department health care personnel who are assigned to duties providing direct patient care, either diagnostic or therapeutic.

2 Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) are required for all Medical Corps Officers detaching to overseas or operational billets before detaching from their current command.

3 Advanced Cardiac Life Support (ACLS) certification is required for providers with Emergency Department privileges, providers assigned to contingency augmentation billets, and those providers standing Transport Watch. ACLS is highly recommended for ALL privileged providers at this facility.

4 Advanced Trauma Life Support (ATLS) certification is required for providers assigned to the Emergency Department, contingency augmentation billets, and highly recommended for all providers at this facility, particularly those assigned to the General Surgery, Orthopedics, and Anesthesia Departments.

5 Age-specific resuscitative medicine (i.e. Adult: ACLS, Child: PALS, Infant: NALS) certification is required as a condition for acquiring privileges in and conducting Conscious Sedation on adult, pediatric, and infant patients, respectively.

(c) All medical staff members shall be responsible for completing the continuing education credit hours required for maintaining their state licensure or certification. The command shall provide opportunities for this continuing education.

(d) Medical staff are responsible for ensuring that continuing education credits earned outside the command are submitted to the Education and Training Department and that the information submitted is correct.

PROCEDURES FOR THE MEDICAL STAFF

1. Patient Rights and Responsibilities

a. The basic rights of human beings for independence of expression, decision, action and concern for personal dignity and human relationships are always of great importance. During sickness however, presence or absence of some or all of the patient's basic rights becomes a vital deciding factor in survival and recovery. Thus, it becomes a prime responsibility for the hospital to endeavor to assure that these rights are preserved for their patients.

b. As per references (g) and (h) and to the extent permitted by law and military regulations, all staff members shall recognize and respect the rights of patients.

c. Pursuant to reference (g), in providing care, hospitals have the right to expect behavior on the part of the patients and their relatives and friends, which, considering the nature of their illness, is reasonable and responsible.

2. Admission Authority

a. Only members of the medical staff who have been granted admission privileges may admit patients to inpatient services. Physicians may not admit patients with diagnoses that are not within the scope of their privileges. CAX physicians are not ordinarily granted admission privileges.

b. In cases where there is disagreement concerning the service to which a patient is to be admitted, the matter shall be immediately referred to the appropriate director(s) for resolution.

c. Emergency Department physicians are not granted admission privileges, and may not write admission orders. Admitting providers may give verbal/telephone orders to a Registered Nurse in the Emergency Department. The nurse will transcribe the orders on a standard order sheet specifically stating "Verbal Order" or "Telephone Order" and the name of the admitting provider giving the orders. The admitting provider is then responsible for the patient as soon as the patient is released from the Emergency Department to the ward, and is responsible for completing the history and physical examination and signing the

admitting orders within 24 hours of admission. Verbal orders may NOT be given to a corpsman.

d. Eligibility for Admission. Only those patients authorized by current directive shall be admitted to the hospital. However, any patient requiring emergency medical care to preserve life or to prevent suffering may be admitted to the hospital without regard to eligibility. In cases of questionable eligibility the admitting member of the medical staff will obtain clarification from the Head, Patient Administration Department during working hours or from the Officer of the Day at other times after admitting the patient.

3. Admission History and Physical Examination

a. Patients admitted to the hospital shall have a history taken and a physical examination performed within 24 hours of admission by a medical staff member who has such privileges. The patient's medical care is the responsibility of a member of the medical staff. Admissions/transfers to the Close Observation Unit require the presence of the admitting physician within 60 minutes of the admission/transfer. The history and physical exam for all patients shall include at least an assessment/screening of each patient's physical, psychological, and social status to determine the need for care or treatment, the type of care or treatment to be provided, and the need for any further assessment. Nurse Midwives may independently admit and follow patients consistent with their scope of privileges (for example routine labor and delivery) without direct physician involvement or physician cosignature on the records. However, physician cosignature is required for any patient for whom the Nurse Midwife requires physician consultation. Non-physician providers may NOT admit patients to the Close Observation Unit.

b. Other individuals who are permitted to provide patient care services independently may perform the history and physical examination, if granted such privileges and if the findings, conclusions, and assessments of risk are confirmed or endorsed by a qualified physician before the performance of surgery or within 24 hours, whichever occurs first.

c. If a complete history and physical examination has been performed within 30 days prior to admission, the original or a legible copy may be used provided there has been no subsequent change or the changes have been recorded in the medical record at

the time of admission in an interim note, dated and signed by the admitting member of the medical staff. The medical record shall document a current, thorough history and physical examination prior to the performance of surgery. If the patient's hospital stay is less than 48 hours, or in the case of a normal delivery/ normal infant, an Abbreviated Medical Record (SF-539) may be used and the history and physical examination must be documented on the SF-539. If the patient remains beyond the anticipated 48 hours, a dictated narrative summary will be utilized to complete the admission.

d. In the case of elective C-sections, a SF-539 may be used in conjunction with the Prenatal and Pregnancy Form (SF-533) in order to complete the requirements of a thorough history and physical. A dictated narrative summary is required for all C-section patients.

e. The history and physical form shall contain a statement of the conclusions or impressions drawn from the admission history and physical examination and a statement of the course of action planned for the patient while in the hospital. The admission note must be written or endorsed by the responsible medical staff member.

f. The admitting medical staff member shall indicate in the admitting orders the primary admitting diagnosis (established or provisional). If two or more conditions are present upon admission, the admitting physician shall designate, as the primary diagnosis, the more serious condition for which the patient was admitted. Under no circumstances will the admission diagnosis(es) be stated as a procedure (e.g. Appendectomy for Appendicitis).

g. Case Management Team: Direct admissions or transfers to Naval Hospital Twentynine Palms from other facilities may require collaboration among various disciplines to determine whether all required services will be able to be provided at this MTF. The accepting physician is responsible for ensuring that the patient can be appropriately managed at this facility. Questionable cases tend to be facility-limiting rather than admitting physician-limiting. In questionable cases, the accepting physician will discuss the patient's expected medical, surgical, nursing, and ancillary services needs with appropriate representatives from those disciplines. Consensus will be

reached before the patient in question is admitted. In the case of a patient already admitted to the facility, if questions arise as to whether the patient can be appropriately managed at this facility, the appropriate disciplines will meet to discuss the case and arrive at an acceptable conclusion. Unresolved conflicts will be expeditiously forwarded up the chain for resolution.

4. Cancellation of Admission

a. Once admission procedures have been accomplished and treatment of any sort has been initiated, exclusive of routine laboratory or radiology examinations, an admission cannot be cancelled. Such care rendered shall be documented in the patient's clinical chart. The discharge narrative summary may be legibly hand written on the Abbreviated Clinical Record (SF-539) if the extent of treatment is such as to require only a brief note. If additional space is needed, a Doctor's Progress Notes (SF-509) form may be used. However, the discharge progress note must be on the SF-539. Reason for admission and reason for cancellation must be legibly documented on the SF-539 or progress note.

b. If, after admission procedures have been completed, but prior to rendering inpatient care and treatment, the admission is deemed inappropriate, the admission may be cancelled. The Head, Patient Administration Department must be notified immediately. In such cases, the patient's name shall be stricken from the admission log and that patient's register number reissued. Cancellations are permitted only if the patient is admitted and released within the same census day (0001-2400). The reason for admission and cancellation must be documented on the SF-539 or the SF-509. Reports of laboratory or radiology examinations will be filed in the patient's outpatient medical record.

5. Orders

a. Preadmission/Admission orders. The admitting medical staff member is responsible for assuring that appropriate diagnostic and therapeutic procedures are ordered in a timely manner. Orders for consultations for patients requiring discharge planning services should be initiated at the time of admission or as early as practical.

b. Orders may be written by medical staff within the limits

of their privileges at this Command. With the exception of routine uncomplicated vaginal delivery patients attended by Nurse Midwives, all inpatient orders written by non-physician medical staff must be countersigned by the responsible attending physician. Unless otherwise required by written departmental policy, countersignature does not need to occur prior to implementation of the order.

c. All orders must be in writing and must be legible. An order shall be considered to be in writing if it is dictated to a registered nurse and countersigned within 24 hours. Telephone orders shall be given only by a member of the medical staff. The medical staff member giving the order shall ensure that the order is countersigned within 24 hours. Any registered nurse who is charged with the responsibility of carrying out a telephone or verbal order is authorized to verify the identity of the ordering physician, to question the validity or appropriateness of the order, and to request that the order be written. In the event of disagreement, the matter shall be immediately referred through the chain of command for resolution.

d. All medication orders will be automatically discontinued when a patient goes to surgery. New medication orders must be written when a patient returns from surgery.

e. All drug orders for narcotics, sedatives, steroids, antineoplastics, hypnotics, anticoagulants, antibiotics and preparations containing ergot or its alkaloids will be automatically discontinued after 48 hours unless the order indicates the exact number of doses to be administered, the exact duration of the medication, or the medication is reordered.

f. Orders not to resuscitate shall be accomplished in accordance with references (j) and (r).

6. Consent

a. Reference (i) defines the requirements of informed consent.

b. The patient has the right to receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the proposed course of treatment. Except in emergencies, this information should include a description of the procedure or treatment, the

medically significant risks involved in each, and the name of the person who will carry out the procedure or treatment.

c. It is the responsibility of the treating provider to obtain the informed consent. In no event shall the provider delegate the responsibility of advising and informing the patient or other person authorized to sign for the patient.

d. The treating provider should enter a note in the medical record indicating that a discussion was held with the patient and an informed consent was obtained. Risks, alternatives, and benefits of procedure should be clearly documented.

e. In addition to the medical record entry, written verification of informed consent is documented on the Standard Form 522 (Request for Administration of Anesthesia and for Performance of Operations and Other Procedures). Expressed consent involves an interchange of language by which the patient, or person authorized to act on the patient's behalf, specifically states that consent is given to the proposed medical care. Written consent should be recorded on a Standard Form 522 (except in emergency situations) in connection with the following:

(l) Any major or minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia or sedation is used, whether or not an entry into the body is involved, excluding local/digital infiltration for closure of simple lacerations or insertion of an IV.

(3) Any non-operative procedure which involves more than a slight risk of harm to the patient or which involves the risk of a change in the patient's body structure.

(4) Transfusion of blood or blood products.

(5) Any other procedures which by written departmental policy or in the opinion of the attending provider require a written consent. Any question as to the necessity or advisability of obtaining a written consent form on behalf of the patient should be resolved in favor of procuring such a consent.

g. The Standard Form 522 is not informed consent; it is

documentation for both the hospital and the provider that informed consent has been obtained. Therefore, it must be remembered that the form is not a substitute for the critical role of the attending provider in the informed consent process. A provider not involved in the procedure or another staff member shall serve as a witness to the patient's signing of the form.

h. Duration of an informed consent. An informed consent may be considered to have continuing force and effect until such time as there are changed circumstances which would materially affect the patient's understanding of the nature of or the risks of such procedure and/or the alternatives to such procedure. For example, if a patient has been admitted for a specific course of treatment, including a specific operation, but in the course of studying the patient, several days elapse and the anticipated operation changes considerably, the provider should obtain a new informed consent. An exception is in the case of antepartum care, when consents may be completed for routine procedures that relate to the birthing process.

i. Medical emergencies. The hospital cannot permit any treatment, without risk of liability, unless the patient or a person legally authorized to act on behalf of the patient, has consented. In the case of a medical emergency, i.e., where treatment appears to be immediately required and necessary to prevent deterioration or aggravation of the patient's condition, treatment may proceed without patient consent. The law implies consent in these circumstances on the theory that if the patient were able or if a legal guardian were present, such consent would be given. The attending provider should ensure compliance with the following:

(l) Determination of existence and nature of emergency: A provider must determine whether the treatment appears to be immediately required and necessary to prevent deterioration or aggravation of the patient's condition. In addition, the scope of the emergency must be determined. Treatment may be a matter of first aid or temporary medical care in lieu of surgery or actual surgical procedures. In other words, treat the emergency only.

(2) Consultation: There is no legal requirement that the provider seek consultation. Consequently, it is a matter of discretion for the treating provider to determine if consultation is advisable in confirming the existence of the emergency.

j. Otherwise obtaining consent: The possibility of obtaining the necessary consent from either the patient, if capable (e.g., conscious), or another person legally capable of consenting should be assessed and weighed against the possibility that a delay for consent would result in deterioration or aggravation of the condition of the patient. If delay for purposes of obtaining consent would not so jeopardize the condition of the patient, it must be obtained and the guidelines otherwise contained in the section on consent to treatment would apply.

k. Documentation in patient chart: The medical determination that an emergency exists should be carefully charted by the provider (e.g., "The immediate treatment of the patient is necessary because..."). The provider shall not sign a consent form on behalf of the patient. Such consent is implied by law from the existence of the emergency. If the provider has obtained consultation, the consulting physician should similarly document this opinion in the patient's chart.

7. Progress Notes: Dated and timed progress notes must be recorded whenever there is a significant change in a patient's condition or treatment plan. Patients must have evaluation documented in the chart by the provider at the minimum frequency required by any departmental policy, but no less frequently than once daily. A discharge progress note must be written prior to discharge or transfer of the patient. Opinions requiring medical judgment shall be written or authenticated only by medical staff members. Progress notes by non-physician providers do not require medical staff countersignature. The responsible medical staff member should ensure that the progress notes give a pertinent chronological report of the patient's course in a hospital and reflect any change in condition or results of treatment.

8. Reports of Procedures and Test Results (INPATIENT)

a. Initial laboratory and radiology reports will generally be available to the ordering provider on CHCS (Composite Healthcare Computer System) before the paper copy is available.

b. Original laboratory and radiology paper reports for inpatients shall be forwarded directly to the ward. Original inpatient reports must be reviewed and initialed by the provider and filed in the inpatient record. All inpatient reports will be delivered to the Inpatient Records Division. Inpatient Records

Division shall place any reports which have not been initialed into a folder in the provider's chart review box.

9. Reports of Procedures and Test Results (OUTPATIENT)

a. Laboratory and Radiology reports will generally be available to the provider on CHCS (Composite Healthcare Computer Service) before the paper copy is available.

b. Original laboratory and radiology reports for patients in an outpatient status shall be forwarded directly to the clinics or placed in their distribution boxes by the Laboratory or Radiology Department. Likewise, any reports of outpatient diagnostic or therapeutic procedures (e.g. Pulmonary Function Tests, audiograms, etc) will be forwarded to the clinic or provider ordering the test or treatment. The provider will verify, by initialing the chit or report, that the results have been reviewed, and within 7 days will forward the chit/report to the Outpatient Records Division for incorporation into the patient's medical record. The provider should record any significant abnormal laboratory, radiology, etc. findings in the patient's medical record and the patient should be notified of the results, if necessary.

c. If the provider is to be absent for longer than one week, the reports shall be reviewed and initialed by the provider who is covering. The Head, Emergency Medicine may review and initial reports for contract physicians.

d. These reports are to be filed in the medical record within a few days of receipt in the Outpatient Records Division.

e. Identification Data. All staff members are directed to ensure that patient identification is complete and correct. Except in an emergency, laboratory, radiology procedures, or EKG interpretations shall not generally be accomplished without complete and correct patient identification information recorded on these requests. Under no circumstances is the Lab to refuse to run a test without making the provider aware of the situation. If the provider is unavailable, the test should be run.

f. Recall: When incidents occur within the Laboratory or Radiology Departments that result in the inability to conduct the requested test either through loss of the specimen or equipment malfunction, the responsibility for recalling the patient shall

be vested with the Laboratory or Radiology Department as applicable, preferably after the provider has been notified. If the Lab or Radiology Department is unable to reach the patient, the requesting provider will be notified.

g. Reporting of Panic Values: Outpatient panic values will be reported to the physician by phone or beeper. If the requesting physician is not available, the value will be reported to the duty physician. Inpatient panic values will be reported to the ward. Specific Panic Value parameters are detailed in the Laboratory Policy and Procedures Manual.

9. Serious or Very Serious Condition and Death Procedures are contained in reference (i).

10. Advance Directives: The Patient Self-Determination Act (PSDA) mandates that hospitals inform all patients of their rights, according to state law, to make decisions concerning their medical care. This includes their right to accept or refuse treatment and the right to prepare advance directives. Advance directives state a patient's choices about treatment or name someone to make such choices, should the patient become incapable of making health care decisions for himself/herself. Reference (j) outlines the procedures for making this information available to patients. Staff members are prohibited from assisting patients in making the actual decision and are prohibited from serving as witnesses on any such documents.

11. Death procedures. Death procedures differ depending on the category of patient, the location, and the circumstances of death. The Decedent Affairs Officer shall assist the medical staff and the next of kin in accomplishing the required procedures. Members of the medical staff shall ensure that all procedures related to the care of the dead are performed with dignity and respect and that relatives and friends of the deceased are treated with the utmost courtesy and tact. Responsibility of the attending physician include but are not limited to the following:

a. Render the official pronouncement of death.

b. Make appropriate entries in the medical record attesting to pronouncement of death, time, date, cause (if known) and other pertinent facts as may be of future medico-legal significance.

All medical records shall be brought up to date and forwarded to the Decedent Affairs Officer, Patient Administration Department.

c. Dictate Death Summary.

d. When the next of kin is present, promptly notify causes of death. Follow specific procedures described in this instruction when the next of kin is not present.

e. Determine necessity for postmortem examination and if indicated, make this requirement known to the next of kin. All medical staff members are expected to be actively interested in obtaining autopsies. Deaths in which an autopsy is encouraged include those cases in which the cause of death is not entirely clear, post mortem findings would assist in determining the extent of disease or injury, or other cases in which post mortem examination would clearly assist in the furtherance of medical science. Findings from autopsies shall be used as a source of clinical information in Performance Improvement activities. The next of kin's decision regarding consent must be relayed to the Decedent Affairs Officer by way of the Authorization for Autopsy (SF-523).

f. Ward personnel shall advise the Decedent Affairs Officer or Officer of the Day when reporting a death. All deaths shall be personally or telephonically reported immediately to the Commanding Officer or his representative and the Report of Death Form 6320/5 shall be prepared in triplicate.

12. Organ or Tissue Donation: Although this hospital does not have the facilities to harvest donated organs, every effort should be made to respect the wishes of potential donors. This includes:

a. Encouraging beneficiaries to fill out organ donor cards.

b. Ensuring that transferring facilities are apprised of potential organ donor status of seriously ill or injured patients.

c. Considering the possibility of transferring seriously ill or injured patients to facilities which can harvest organs.

l3. Discharge or Transfer to Another Medical Treatment Facility

a. All transfers of inpatients to another medical facility shall be directed to the Patient Administration Department during normal working hours or Officer of the Day after normal working hours. Such referral is essential in order to ensure that:

(l) Required transportation is arranged.

(2) Medical records (clinical chart, narrative summary, lab reports, radiographs) are completed, collected and duplicated as necessary to accompany the patient.

(3) Current regulations and procedures are followed as established by higher authority. This is particularly important in cases involving transfer of active duty personnel.

b. Criteria: Patients shall generally not be transferred to other medical treatment facilities except to obtain care which is beyond the capability of this hospital. This includes the need for:

(l) Intensive Care Unit (ICU), Coronary Care Unit (CCU), PICU (Pediatric Intensive Care Unit), NICU (Neonatal Intensive Care Unit).

(2) The need for specialty or subspecialty services not provided at this facility.

(3) Exceptions to this policy may be considered when:

(a) In the case of active duty personnel, transfer to a Veterans Administration Hospital for further care is medically indicated or provided that such transfer is incident to the member's retirement or separation for physical disability.

(b) The eligibility of the patient ceases or is limited by regulations.

(c) When the determination is made that due to staffing or other constraints, the hospital cannot care for the patient.

c. Procedure: When transferring a patient to another medical treatment facility, the attending physician will:

(l) Notify and obtain an accepting physician at the

receiving facility and confirm that the patient meets the hospital's admission criteria relating to appropriate bed, personnel and equipment necessary to treat the patient.

(2) Indicate in the discharge/transfer note why the patient is being transferred to another facility. The attending physician shall ensure that the patient is stable enough for transfer. Unstable patients will be stabilized to the best extent possible prior to transport to another facility.

(3) Ensure that a transfer summary accompanies the patient.

(4) Call the Patient Administration Department during normal working hours and the Officer of the Day after normal working hours to provide the necessary information to arrange the transfer and information concerning medical records which will accompany the patient.

(5) Dictate a discharge summary. To permit expeditious transfer of a patient in an emergency situation, a discharge note may be handwritten; however, this practice will not obviate the requirement for a narrative summary to be dictated at the earliest possible date to ensure completion of the clinical record.

(6) When a healthcare provider is required to accompany a patient, he/she must review the examination and evaluation by the attending physician prior to departing this hospital. The accompanying provider must have the appropriate resuscitative medicine certification (ACLS, ATLS, PALS, NALS) and be qualified to reasonably manage clinical problems which might arise en route to the accepting facility.

14. Discharge Procedures. Patients may be discharged or transferred only upon the written order of the responsible healthcare provider. Discharge procedures include the following:

a. The primary prerequisite for attending healthcare providers to consider before discharging any patient shall be whether discharge is medically indicated at that time. Personal, family or command convenience shall not override the attending provider's judgement of when discharge is appropriate. Neither shall the discharge of a patient, when medically indicated, be unnecessarily delayed by hospital administrative process.

Patients may routinely be discharged from 0800 to 1600 on normal working days and may be discharged after hours only if all the following conditions are met:

(l) The discharge is medically indicated.

(a) Personnel are available for processing of appropriate medical records.

(b) Appropriate transportation from the hospital is available.

b. The "Discharge Note" shall be completed for all inpatients. If appropriate, the Abbreviated Medical Record (SF-539) (hospitalizations of 48 hours or less) and Interim Report of Inpatient Disposition (NH29P 6320/70) forms shall be completed. The original shall be placed in the Inpatient record and a copy shall be placed in the Outpatient record.

c. Narrative summaries shall be dictated in accordance with current command instructions.

(l) Dictation of the discharge narrative summary must be accomplished within one week after discharge.

(2) The narrative summary should concisely state the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge and any specific instructions given to the patient and/or family. Consideration should be given to instructions relating to physical activity, medication, diet, and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition of admission, avoiding the use of vague relative terminology such as "improved". When preprinted instructions are given to the patient or a family member, the record should so indicate. A copy of the narrative summary should be included in the Outpatient record.

(3) The Abbreviated Medical Record (SF-539) may be substituted for the narrative summary in the case of patients with problems of a minor nature who require less than a 48 hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The discharge

note in the progress section of the SF-539 must be completed and legible and shall include all discharge final diagnoses, date of discharge and any instructions that were given to the patient and/or family.

d. In the event of death, a dictated death summary should be added to the record either as a final progress note or as a separate resume. This final note should indicate the reasons for admission, the findings and course in the hospital and the events leading to death.

e. In the event of transfer, a transfer summary may be used in place of a discharge summary.

15. Use of Medical Abbreviations: The use of common medical abbreviations are permitted as recommended in reference (k). Abbreviations will not be used on the Inpatient Admission/ Disposition Record or in the discharge summary.

l6. Identification of Healthcare Providers

a. The Manual of the Medical Department requires that the name and rank of providers making entries in the health record shall be typed, printed, or stamped under the signature. Paper (i.e., non-computer generated) medication prescriptions similarly require the printed or stamped name and rank of the provider. Paper prescriptions for controlled substances require the provider's social security number, in the case of military providers, or the Drug Enforcement Agency (DEA) number in the case of civilian/contract providers.

b. All healthcare providers will be issued a stamp by the Head, Patient Administration, with the above identifying data which is to be used on paper prescriptions and all entries in the medical record where signatures are required. When the stamp is not available, the same information must be printed legibly below the provider's signature.

17. Access, Custody and Handling of Medical Records

a. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a directing court order, subpoena, or statute. All medical records, both inpatient and outpatient, are the property of the United States Government. Records may not be removed or released without

permission from the Head, Patient Administration Department in accordance with the Manual of the Medical Department and Manual of the Judge Advocate General. No member of the staff has the authority to release a medical record to a patient, his/her representative or anyone else. No member of the staff has the authority to retain in their possession the medical record of any patient for longer than 24 hours. In case of readmission of the patient, all previous records shall be made available for the use of the medical staff when requested.

b. When certain portions of the medical record are so confidential that extraordinary means are considered necessary to preserve their privacy, such as in the treatment of some psychiatric disorders and Family Advocacy Program records, these portions may be stored separately, provided the complete record is readily available when required for current medical care or follow-up, for review functions, or for use of Performance Improvement activities. The medical record should indicate that a portion has been filed elsewhere in order to alert authorized reviewing personnel of its existence.

c. All staff members are accountable for prompt and appropriate completion of their medical record entries. Inpatient records must be prepared for forwarding to the Inpatient Records Division at the time a patient is discharged from the hospital. Outpatient records must be expeditiously returned to the Outpatient Records Division after the provider completes his/her entries in the record.

d. Inpatient medical records are considered delinquent if they are incomplete 30 days after the date of the patient's discharge. The definition of a completed inpatient medical record is that the history and physical examination, diagnostic and therapeutic orders, operative reports, special reports such as consultations and laboratory reports, clinical notes, final diagnoses and narrative summary or medical board are entered and the record is dated and signed by the medical staff member responsible for the patient. In order to avoid delinquencies, all medical staff members should check with Inpatient Medical Records at least weekly. Medical staff members who have delinquent records will not be authorized leave, TAD, or allowed to PCS until those records are completed.

e. No medical staff member should be permitted to complete a medical record on a patient unfamiliar to him in order to

retire a record that was the responsibility of another staff member who is unavailable. No medical record shall be filed until it is complete, except on the approval of the Head, Patient Administration Department with the endorsement of the appropriate Medical or Surgical Directors and then only after all efforts to complete the records have been exhausted. Any incomplete record which is filed must be noted in the minutes of the Medical Records Review Committee. The Head, Patient Administration shall notate in the medical record that it is to be filed incomplete by order of the Medical Records Review Committee as of the date.

f. Free access to the medical record of patients shall be afforded to medical staff members for bona fide study and research. This access must preserve confidentiality of personal information. Records may only be checked out with the approval of the Head, Patient Administration Department.

18. Medical Records and the Medical Staff

a. All medical staff members are accountable for assuring that their medical records are clinically pertinent, timely, legible, authenticated and are in compliance with command instructions. All documentation must include examinations, lab, or radiographic studies requested and any consultations that may have occurred. Medical records review requirements are contained in references (b) and (l).

b. For patients receiving ambulatory care services, the medical record must include a Summary of Care (Problem Summary List) NAVMED 6150/20, per reference (a), which contains a summary of known significant diagnoses, conditions, procedures, drug allergies, current medications, and appropriate health maintenance monitors. The Problem Summary List is to be initiated and maintained for each patient seen for continuing ambulatory care (three or more ambulatory visits).

c. All providers must clearly document how the medical treatment plan was presented to non-English speaking or other patients with barriers to communication.

19. Consultations

a. All medical staff members are responsible for assuring that consultations are obtained when indicated. When an emergency exists such that the delay required to obtain an

indicated consultation would jeopardize a patient's welfare, the provider in charge may proceed with treatment without consultation. In such an instance, the provider must promptly enter a full explanation in the medical record indicating the circumstances that caused the failure to obtain consultation.

b. Required Consultations: Occasions in which consultations shall be obtained include, but are not limited to the following:

(l) Cases in which according to the judgment of the healthcare provider, the patient is not a good risk for operation or treatment, the diagnosis is obscure, or there is doubt as to the best therapeutic measures to be utilized.

(2) Cases in which the proposed treatment may interrupt a known or suspected pregnancy.

3) Cases of attempted suicide or drug overdose which shall be referred for psychiatric or psychological evaluation.

(4) Cases in which the patient demonstrates alcohol/drug abuse which shall be referred to the Combined Drug and Alcohol Counseling Center for evaluation.

(5) Cases of suspected child or spouse abuse/neglect or sexual assault/rape which shall be referred to the Family Advocacy Representative for evaluation.

(6) Any patient that presents with the same complaint twice in a single episode of care to a non-physician provider. (This does not apply to patients returning for treatment of chronic illnesses previously documented in their medical records). Either the Chronological Record of Medical Care (SF-600) or the Consultation Sheet (SF-513) may be utilized for documentation of the above.

(7) All patients with two presentations to the Emergency Department for the same complaint within 24 hours for other than minor problems or scheduled follow-up shall have a referral to the appropriate specialty.

c. The Consultation Sheet (SF-513) is to be completed in duplicate and embossed with the patient's healthcare card, or printed with the patient's identification data. If the requestor desires follow-up, he/she shall indicate the type of follow-up

requested; e.g., "Request telephone follow-up at (phone number)" or "Copy of consult to (name and address)". When a copy is requested, the consultant shall place the original in the medical record, forward the first copy to the requestor and retain the second copy for his/her department files.

d. The requestor must identify the urgency of the problem using one of the four options provided on the Consultation Sheet. In the case of "Emergency" or "Today" or "72 hours" urgency options, the requestor must communicate directly with the consultant. The consultant shall answer the consultation in the time frame requested or promptly notify the requestor of the inability to do so. In the case of "Routine" consults in which time is an important factor in the management of the specific problem, the requesting provider should document the maximum time period for the consult and instruct the patient to communicate if unable to obtain an appointment.

e. The requestor should specifically delineate what services are being requested. When a requestor desires that the consultant assume responsibility for a patient's care, this should be explicitly stated on the Consultation Sheet. Responsibility for the patient should not be assumed by the consultant until requested by the referring responsible provider. The consultant should indicate in writing whether or not he/she accepts responsibility for the patient's care. Acceptance of responsibility is assumed to have occurred if the consultant admits the patient to his/her service. If the consultant disagrees with the requested level of his/her involvement, the consultant shall personally contact the requestor and together arrive at a treatment course.

f. The consultant should be qualified to give an opinion within the field in which his/her opinion is sought. The consultation report should contain a written opinion by the consultant that reflects an examination of the patient and the patient's medical records.

g. When the duty Emergency Department physician determines that a patient should be referred to another facility's Emergency Department for after hours specialty consultation, the receiving Emergency Medicine Department physician shall be notified. The Naval Hospital Emergency Department physician remains responsible and has final authority for appropriate disposition in all cases unless care has been specifically assumed by an on-call specialist who is physically present.

h. If a consultant feels that additional specialty consultation is required, he shall provide a courtesy copy of the consultation request to the primary provider.

20. Family Advocacy Program. All staff members shall ensure compliance with Family Advocacy Program requirements as outlined in reference (m). Procedures include the following:

a. The Family Advocacy Program includes the identification, evaluation, intervention, treatment and prevention of abuse, neglect, sexual assault and rape.

b. The Family Advocacy Program is under the control and management of Marine Corps Air Ground Combat Center, Family Services Center. The Naval Hospital shall support and maintain membership to all Family Advocacy committees and act as the medical representative to the meeting.

c. A member from the Family Services Center is designated as the Family Advocacy Representative (FAR). The Officer of the Day is the Duty Family Advocacy Representative (DFAR) after regular working hours. In the absence of the FAR, the DFAR provides guidance and assistance to medical personnel responding to the abuse, neglect, sexual assault or rape incident.

d. Emergency response to family members in imminent danger: Emergency response to reports of abused or neglected children and/or spouses in immediate danger of death or bodily harm shall be in accordance with this instruction.

(1) In those cases where the victim of child or spouse abuse is considered to be in real or present danger of death or serious bodily harm, the provider shall initiate immediate action to remove the victim from the situation placing them in danger, provide required medical care, secure protective custody in cases of child abuse and provide shelter care to ensure health, welfare and safety.

(2) In all incidents requiring emergency response, the FAR/DFAR shall be immediately notified and consulted to ensure compliance with all legal requirements.

e. Examination of suspected abused or neglected individuals. The nature of child or spouse abuse and neglect necessitates careful and thorough examination in order to identify or rule out

past and present injuries that are not visible or obvious. This examination shall be conducted in accordance with this instruction.

f. Medical investigation of alleged or suspected sexual assault and rape: Procedures for the care, evaluation and full medico-legal documentation of cases of alleged or suspected sexual assault/rape of adults or minors shall be accomplished in accordance with this instruction.

(1) The following staff members shall be immediately notified:

(a) The Family Advocacy Representative (FAR) or

(b) Duty Family Advocacy Representative (DFAR).

(2) If the alleged victim is an adult, the appropriately trained provider (Emergency Department Physician, OB/GYN or Family Practice provider) shall take responsibility for examination, gathering of evidence, and treatment. In the case of adult male sexual assault victims, referral to the appropriate specialty service may be indicated (e.g. General Surgery at this MTF or Urology at Naval Hospital, San Diego or Camp Pendleton).

(3) If the alleged victim is a child, the Pediatrics Watch shall take responsibility for examination, gathering of evidence, and treatment.

(4) An appropriate person (e.g. nurse/chaplain) of the victim's gender may be assigned to be with the subject throughout the evaluation. The victim should be attended at all times if possible.

(5) Required emergency treatment shall be rendered without delay.

g. Reporting identified incidents of suspected or known abuse: Medical personnel in all departments will notify the FAR/DFAR of all cases in which abuse, neglect, sexual assault or rape is suspected or known to have occurred. The evaluating physician will report the incident to the Provost Marshall's Officer (PMO), who will then report to the Naval Criminal Investigative Service (NCIS). NCIS will report to the appropriate civilian and military agencies in accordance with Family Advocacy Protocol.

21. Reportable Diseases: All staff members are responsible for compliance with reporting requirements of reference (n). Compliance is essential to ensure that contacts of diseases are not left unprotected. The Head, Occupational Health/Preventive Medicine Department shall be notified of any disease listed in this instruction. For after hours evaluations and diagnosis of reportable diseases, the staff shall make a copy available to the Preventive Medicine Department the following work day.

22. Reporting seizures, syncope, and visual impairment in patients to the Department of Motor Vehicles: California State Law requires the reporting of these conditions for persons of driving age. Medical staff caring for these patients shall report all such conditions to the Head, Preventive Medicine Department who is responsible for forwarding the required documentation to the Department of Motor Vehicles.

23. Reporting and Treatment of Animal Bites: Every animal bite victim will be evaluated by a privileged provider. The utilization of anti-rabies vaccine and/or serum shall be governed by the indications for specific post-exposure treatment. The medical staff member should contact the Environmental Health Officer and complete the Animal Bite Report prior to discharge of the patient. Additionally, the appropriate public health authorities shall be contacted by telephone as soon as possible after the animal bite occurrence.

24. Reporting of Unexpected Events

a. Shall be accomplished pursuant to reference (o). All medical staff members are accountable for compliance with all command Unexpected Event reporting requirements. All events meeting command screening criteria must be promptly reported. All reports shall be submitted to the Risk Manager.

b. Adverse Drug Reactions: These reports may be forwarded by the provider directly to the Head, Pharmacy Department or to the Risk Manager. The Risk Manager shall forward these reports to the Head, Pharmacy Department, and Chairman, Pharmacy and Therapeutics Committee for assessment, completion of appropriate reports and follow-up monitoring. Reference (w).

25. Nosocomial Infections. Both inpatient and outpatient hospital acquired infections shall be reported. The Infection Control Nurse shall forward these reports to the Infection Control Committee for assessment and follow-up monitoring.

26. Anesthesia Services

a. All medical staff members utilizing or providing anesthesia services in the Main Operating Room or PACU (Post Anesthesia Care Unit) are responsible for compliance with the requirements in the Anesthesia Department Policy and Procedures Manual. The following policies and procedures are included:

(1) Surgical scheduling.

(2) Procedures for emergency operations.

(3) Preoperative preparation of the surgical patient.

(4) Cancellation procedures.

(5) Postoperative care.

(6) Anesthesia safety regulations.

(7) Intravenous sedation.

b. The preanesthesia assessment includes at least the following:

(l) Evidence of a patient interview verifying past and present medical and drug history and previous anesthesia experience(s).

(2) Documentation of the American Society of Anesthesiologists Physical Status (ASA 1 = IPS Classification 1-5) as evidence of a patient physical profile.

(3) Results of relevant diagnostic studies.

(4) Preoperative diagnostic studies are performed on a case-by-case basis at the physician's discretion.

(5) Plan (choice) of anesthesia.

(6) High risk patients require a preoperative anesthesia consultation in order to optimally prepare them for a safe anesthetic.

(7) All females of child bearing age and potential are required to have a pregnancy test done prior to surgery.

c. Discharge of same-day patients by the surgeon presupposes no anesthesia complications; therefore it is not necessary to have a post-anesthesia note written by the Anesthesia Department when same-day surgery patients are discharged by the surgeon.

d. Conscious Sedation Policy: Ref (v)All providers who perform procedures employing conscious sedation shall be trained and certified in the age-appropriate resuscitative medicine course (ACLS, NALS, PALS), and shall meet criteria outlined in the Command Conscious Sedation Policy.

27. Surgical Services

a. A surgical operation shall be performed only with appropriately documented informed consent, history and physical examination and preoperative diagnosis. In an extreme emergency, that is, one in which there is threat to life, limb, or permanent disability, that note may be written postoperatively but must detail why the entry was not written preoperatively.

b. Surgeons shall be in the operating room and ready to commence an operation at the time it is scheduled. The responsible surgeon must have privileges to perform the procedure.

c. The responsible surgeon will ensure that there are a sufficient number of qualified personnel available for each surgical procedure.

d. All tissues removed at surgery, unless specifically exempted by ECOMS, must be sent to the Laboratory Department. A pathologist shall make such examination as considered necessary to arrive at a pathological diagnosis. The categories of specimens that may be exempted from the requirement for an examination by a pathologist are limited to the following:

(1) Foreign body

(2) Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics.

(3) Ingrown toenails and portions of fingernails and toenails removed/damaged by trauma

(4) Curetted warts, molluscum contagiosum, skin tags less than two millimeters in diameter

(5) Specimens removed for chromosomal, culture, or other laboratory examination

(6) Teeth

(7) Penile foreskin removed in circumcision

(8) Orthopedic hardware

(9) Cicatrix

e. All operations performed shall be immediately and fully described by the operating surgeon's dictation and by an entry in the medical record.

f. Operative reports shall include a description of the findings, technical procedures used, the specimen(s) removed, preoperative diagnosis, instrument count, postoperative diagnosis, the name of the primary surgeon and assistants, the type of anesthesia used and an estimate of the blood loss. The responsible surgeon must be designated in the operative report, even if his/her participation in the case was only supervisory. The completed operative report shall be signed by the responsible surgeon and filed in the medical record as soon as possible after transcription.

g. A brief written note shall be entered into the medical record immediately after surgery and shall provide all the pertinent information necessary for use by any provider who may be required to attend the patient.

h. The following procedures do not require a dictated operative report, but will require full documentation on Progress Notes (SF-509), Chronological Record of Medical Care (SF-600), or Abbreviated Clinical Record (SF-539):

(l) Routine vaginal deliveries

(2) Minor procedures

(3) Endoscopies require completion of Endoscopy Report (NAVHOSP Form 6l50/26).

28. Laboratory Services. Procedures for utilization of laboratory services are contained in the Laboratory Department Policies and Procedures Manual.

29. Emergency Services: Level II Emergency Services are provided at this hospital. Medical Staff members attending to patients in the Emergency Department are responsible for compliance with the requirements of the Emergency Medicine Department Policies and Procedures Manual.

The Emergency medicine Department has an effective mechanism for dealing with abnormal lab results (e.g. cultures) and abnormal radiographs which are reported after the patient has been discharged from the Emergency Department. Details are contained in the Emergency Department Policies and Procedures Manual.

30. Special Treatment Procedures. The Naval Hospital does not maintain any Psychiatric beds. Patients requiring inpatient psychiatric care will be referred to other Military Treatment Facilities in the case of active duty patients. Family members and retirees may also be referred to military Medical Treatment Facilities on a space available basis or to civilian hospitals within the geographical area.

3l. Restraint and Seclusion: Seclusion is NOT available at Naval Hospital Twentynine Palms. The policy on restraint of patients is outlined in reference (p). Mechanical restraint against a patient's will or without his/her consent is an unusual and temporary measure of last resort. Restraints are rarely indicated at this facility. The monitoring and documentation requirements are extremely stringent. Restraint Orders can be made only by licensed independent practitioners based on clear clinical justification, must be time-limited, and must respect the patient's rights, dignity, and well-being. PRN Restraint Orders are NOT permitted.

32. Use of Stand-bys: Guidelines for the use of stand-bys are contained in reference (q). Providers shall ensure that a stand-by is present during physical or visual examinations, treatments, or medical procedures of the genitalia or breasts on a patient of the opposite gender. A stand-by will be of the same gender as the patient when resources permit.

33. Orders Not to Resuscitate/Bioethics Review Committee: Requirements for orders not to resuscitate and the functions of the Bioethics Review Committee are contained in reference (r), which includes the following:

a. Only privileged physicians permanently assigned to the Naval Hospital may write orders not to resuscitate. Criteria to be utilized, medical record documentation, and notification requirements are as reported in reference (r).

b. The Bioethics Review Committee functions as a forum for consultation by physicians, patients, or their families and members of the hospital staff regarding treatment decisions having ethical implications such as refusal of treatment, withholding of or withdrawal of life support systems, donation of organs, conflicts between therapeutic research and education priorities or other such matters as may properly come before it.

34. Emergency Recall/Disaster Preparedness. The Command is required to provide medical support services in the event of mass casualties, disasters, and other emergency events. The ability of this command to function in such events rests with the capability to recall the staff to the hospital. Compliance is essential by insuring a 30 minute recall and a 30 road miles residence limit. All medical staff are responsible for compliance with the requirements of reference (s).

35. Medical Watchstanding

a. General: The 24-hour watch period runs from 0730-0730. Providers standing watch must be available by telephone or beeper at all times and must be able to respond to the hospital within 30 minutes.

b. Primary Obstetrics (OB) Watch

(l) Primary OB watchstanders include the OB/GYN physicians, nurse midwives and family practice physicians. When the primary OB watchstander is a nurse midwife or a family physician, a designated OB/GYN physician will serve as backup (secondary) and will be readily available for consultation. The 30 minute recall applies to both the primary and secondary OB watchstander.

(2) The OB watch is responsible for the evaluation, disposition and treatment of pregnant patients after 20 weeks gestation. The Emergency Medicine Department physician may see pregnant patients with unrelated complaints and patients less than 20 weeks gestation. The OB watch may serve as a consultant in these cases.

(3) Assumption of the OB watch is likely to involve transfer of patient care. The oncoming watchstander must be ready to assume care and discuss cases with the departing provider at 0730.

c. Admission Watch (MOOD)

(l) The Admission Watch (generally a Family Practice or Internal Medicine physician) is responsible for the care of patients who require admission to the inpatient service by way of the Emergency Medicine Department, Military Sick Call or Battalion Air Station when the patient does not require other specialty care.

(2) The Admissions Watch assumes care for the patient as soon as the patient leaves the Emergency Medicine Department regardless of whether the Admissions Watch has come in to evaluate the patient. Verbal orders are acceptable, but the watchstander is still responsible for the patient until or unless he specifically transfers care and the patient is accepted by another provider.

d. Transport Watch

(l) The Transport Watch is responsible for the medical evacuation of patients deemed serious enough by the Emergency Medicine Department or transferring physician to require accompaniment by a privileged member of the medical staff to safeguard the patient's health and well-being during transport.

(2) All privileged members of the medical staff with age-appropriate resuscitative medicine training (ACLS, ATLS, PALS, NALS, as indicated) are eligible to act as the Transport Watch.

(3) If the Pediatric Watch is needed to transport a patient, a Family Physician may act as the Pediatric Watch until the return of the Pediatrician.

(4) If an OB-qualified provider is required for transport, the primary OB watch (if a family physician) may be designated as the OB Transport Officer and in these cases the OB Watch is assumed by the backup obstetrician. If the Obstetrician is serving as primary OB Watch then a Family Physician shall be used for transport. (The level of training required of the OB

transport officer must be determined by the OB/GYN specialist in accordance with requirements of the individual case).

36. Evaluation of a Patient at Risk for Psychological Problems

a. Patients who enter an ambulatory care clinic and exhibit signs of psychological impairment may require an evaluation by a mental health specialist.

b. In the event the patient may be expressing suicidal or homicidal ideation a STAT mental health consultation shall be obtained prior to the release of the patient.

c. If in the judgment of the mental health specialist the patient requires inpatient care, the patient will be transferred to the appropriate treatment facility.

d. Any inpatient who develops signs of significant psychological impairment requires an evaluation by a mental health specialist prior to release from the hospital. If in the judgment of the mental health specialist, the patient requires inpatient care for this condition the patient will be transferred to the appropriate treatment facility.

37. Evaluation of patients who suffer the results of alcoholism or drug abuse:

a. Acute: Drug overdose patients and patients with acute intoxication due to alcohol may be admitted to the Close Observation Unit or Multiservice Ward for medical stabilization and clearance. Psychiatric evaluation will be obtained as necessary to dictate subsequent disposition. Transfer to a psychiatric facility would be pursued based upon the patient's medical condition and recommendations of the Mental Health Department. While an inpatient at this facility, unit "chasers" (in the case of active duty) or Naval Hospital personnel will be assigned to stay at the patient's bedside at all times.

b. Chronic: When a provider suspects a patient to have a substance abuse disorder, the provider shall offer a referral to a facility that can provide the appropriate level of care.